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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 11/20/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Lumbar MRI with and without contrast

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

Patient is a male. On 11/26/12, a medical record review noted that previous MRI findings were reviewed. It was noted the need for current and/or future treatment did not appear to be warranted at that time. On 08/27/15, the patient returned to clinic and he reported intermittent pain to the low back and legs. An MRI was reviewed showing a recurrent herniated disc at L5-S1. He had an antalgic gait on the exam, and straight leg raise was positive right greater than left. An MRI with and without contrast to evaluate the current disc was recommended. On 10/08/15, the patient returned to clinic. On exam, he had a positive straight leg raise at 15 degrees on the right and 30 degrees on the left.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 09/25/15, an adverse determination letter was submitted for the requested MRI of the lumbar spine with and without contrast, and it was noted the submitted documentation did not describe the presence of any new changes on neurological exam compared to previous exams to support the request.

On 10/29/15, an adverse determination letter was submitted again noting that the request was non-certified, as there was a lack of documentation of objective findings on physical examination suggesting significant pathology such as neural compression or recurrent disc herniation.

The guidelines state repeat MRI of the lumbar spine should be reserved for those patients who have documented significant change in symptoms and objective assessment, or if there is a question of tumor or infection. The records do not reflect a significant change in findings, and there is no indication if infection and or tumor.

It is the opinion of this reviewer that the request for a lumbar MRI with and without contrast is not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)